Health Financial Systems | WABASH COUNTY HOSPITAL | In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151310	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 9:23 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2013 Time: 9:23 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH COUNTY HOSPITAL (151310) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/29/2013 Time: 9:23 am
Hj4dabuRW:djGq3sSWd.y2TSGLQ:e0
6wcIt0aX8cAL2sAMhcnODUovTs8qUf
UTT5OobkLNOw.bL1

PI: Date: 5/29/2013 Time: 9:23 am
AW80GjMawAoDqD7nkz17Qc71.YDLb0
EqSNW0cZixouQGAACw9ntPN16lH:E2
ze2k0es36R0tMdhI

(Signed) _____
Officer or Administrator of Provider(s)

President/CEO
Title

5/30/13
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-261,932	-354,951	89,966	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	-28,332	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-290,264	-354,951	89,966	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Health Financial Systems | WABASH COUNTY HOSPITAL | In Lieu of Form CMS-2552-10

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FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S Parts I-III | Date/Time Prepared: 5/29/2013 9:23 am

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Encryption Information

ECR: Date: 5/29/2013 Time: 9:23 am
Hj4dabuRW:djGq3sSWd.y2TSGLQ:e0
6wcIt0aX8cAL2sAMhcnODUovTs8qUf
UTT5OobkLN0w.bL1

PI: Date: 5/29/2013 Time: 9:23 am
AW80GjMawAoDqD7nkzl7Qc71.YDLb0
EqSNW0cZixouQGAACw9ntPN16lH:E2
ze2k0es36R0tMdhI

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
	PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	-261,932	-354,951	89,966	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	-28,332	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-290,264	-354,951	89,966	0	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2013 8:08 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 710 NORTH EAST STREET	PO Box: 548			1.00
2.00	City: WABASH	State: IN	Zip Code: 46992-0548	County: WABASH	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	WABASH COUNTY HOSPITAL	151310	15999	1	12/17/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH COUNTY HOSPITAL SWING BEDS	15Z310	15999		12/17/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	WABASH COUNTY HOSPITAL SNF	155365	15999		01/01/1993	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	WABASH COUNTY HOME HEALTH AGENCY	157061	15999		01/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	WABASH COUNTY HOSPITAL HOSPICE	151545	15999		01/01/1996				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 8:08 am

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N	39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 8:08 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2013 8:08 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 8:08 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 8:08 am

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						1,017,880	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2013 8:08 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/15/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/18/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2013 8:08 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE	CARNAZZO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476	JCARNAZZO@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 8:08 am

		Part B Date 4.00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	01/18/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

VOLUNTARY CONTACT INFORMATION | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part V | Date/Time Prepared: 5/29/2013 8:08 am

		1.00	
	Cost Report Preparer Contact Information		
1.00	First Name	JAKE	1.00
2.00	Last Name	CARNAZZO	2.00
3.00	Title	DIRECTOR OF REIMBURSEMENT	3.00
4.00	Employer	ALLIANT MANAGEMENT	4.00
5.00	Phone Number	(502)992-3476	5.00
6.00	E-mail Address	JCARNAZZO@ALLIANTMANAGEMENT.COM	6.00
7.00	Department		7.00
8.00	Mailing Address 1	2650 EASTPOINT PARKWAY	8.00
9.00	Mailing Address 2	SUITE 310	9.00
10.00	City	LOUISVILLE	10.00
11.00	State	KY	11.00
12.00	Zip	40222	12.00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	JANE	13.00
14.00	Last Name	BISSEL	14.00
15.00	Title	CFO	15.00
16.00	Employer	WABASH COUNTY HOSPITAL	16.00
17.00	Phone Number	(260)569-2247	17.00
18.00	E-mail Address	JANE.BISSEL@WCHOSPITAL.COM	18.00
19.00	Department		19.00
20.00	Mailing Address 1		20.00
21.00	Mailing Address 2	710 NORTH EAST STREET	21.00
22.00	City	WABASH	22.00
23.00	State	IN	23.00
24.00	Zip	46992	24.00

HFS Supplemental Information | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part IX Date/Time Prepared: 5/29/2013 8:08 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2013 8:08 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	54,360.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	54,360.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	54,360.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9,150		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		50				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,202	64	2,265			1.00
2.00	HMO	445	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	178	0	178			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		67	67			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,380	131	2,510			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,380	131	2,510	0.00	243.99	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	835	0	4,205	0.00	14.55	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,930	0	14,047	0.00	19.12	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	8.54	24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2013 8:08 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
27.00	Total (sum of lines 14-26)				0.00	286.20	27.00
28.00	Observation Bed Days		0	292			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	330	16	672	1.00
2.00	HMO			131			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	330	16	672	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2013 8:08 am

		Amount Reported 1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	724,997	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,444,089	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	29,020	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	40,493	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	139,544	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	981,435	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	60,190	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	56,792	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,476,560	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-4
Component CCN: 157061 | Date/Time Prepared: 5/29/2013 8:08 am

Home Health Agency I | PPS

					1.00		
0.00	County				WABASH		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	140.00	0.00	0.00	140.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			15999			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	884	0	43	28	955	21.00
22.00	Skilled Nursing Visit Charges	429,800	0	23,380	15,120	468,300	22.00
23.00	Physical Therapy Visits	1,086	0	8	22	1,116	23.00
24.00	Physical Therapy Visit Charges	214,455	0	3,915	4,495	222,865	24.00
25.00	Occupational Therapy Visits	207	0	0	11	218	25.00
26.00	Occupational Therapy Visit Charges	35,235	0	0	2,030	37,265	26.00
27.00	Speech Pathology Visits	22	0	0	0	22	27.00
28.00	Speech Pathology Visit Charges	9,715	0	0	0	9,715	28.00
29.00	Medical Social Service Visits	7	0	0	0	7	29.00
30.00	Medical Social Service Visit Charges	1,190	0	0	0	1,190	30.00
31.00	Home Health Aide Visits	609	0	1	2	612	31.00
32.00	Home Health Aide Visit Charges	49,329	0	81	162	49,572	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,815	0	52	63	2,930	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	739,724	0	27,376	21,807	788,907	35.00
36.00	Total Number of Episodes (standard/non outlier)	157		18	4	179	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	251	0	5	1	257	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-7 | Date/Time Prepared: 5/29/2013 8:08 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/17/2001	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	14	0	14	18.00
19.00		RHB	25	0	25	19.00
20.00		RHA	83	0	83	20.00
21.00		RMC	130	0	130	21.00
22.00		RMB	173	0	173	22.00
23.00		RMA	277	0	277	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	1	0	1	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	24	0	24	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	15	0	15	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	10	0	10	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	4	0	4	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	5	0	5	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	60	0	60	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-7 | Date/Time Prepared: 5/29/2013 8:08 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	7	0	7	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	7	0	7	199.00
200.00	TOTAL		835	0	835	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	15999	15999	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00	N	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	0	0.00	N	205.00
206.00	OTHER (SPECIFY)	0	0.00	N	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,276,174			207.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-9 Parts I & II | Date/Time Prepared: 5/29/2013 8:08 am

Component CCN: 151545 | Hospice I

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	7,334	0	0	0	0	7,334	2.00
3.00	Inpatient Respite Care	79	0	0	0	0	79	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	7,413	0	0	0	0	7,413	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	0	0	0	0	0	0	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-10 | Date/Time Prepared: 5/29/2013 8:08 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.371121	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,367,068	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	242,502	5.00
6.00	Medicaid charges	5,789,998	6.00
7.00	Medicaid cost (line 1 times line 6)	2,148,790	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	539,220	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	539,220	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,915,383	0	1,915,383	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	710,839	0	710,839	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	710,839	0	710,839	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,858,594	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	407,479	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	2,451,115	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	909,660	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,620,499	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,159,719	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		395,574	395,574	0	395,574	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,205,983	1,205,983	1,916	1,207,899	2.00
4.00	00400	EMPLOYEE BENEFITS	142,167	423,928	566,095	6	566,101	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	1,358,183	2,867,266	4,225,449	8,770	4,234,219	5.01
5.02	00560	BUSINESS OFFICE	389,335	680,472	1,069,807	0	1,069,807	5.02
6.00	00600	MAINTENANCE & REPAIRS	311,675	361,370	673,045	0	673,045	6.00
7.00	00700	OPERATION OF PLANT	0	527,475	527,475	0	527,475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	288,206	447,585	735,791	0	735,791	9.00
10.00	01000	DIETARY	459,582	617,776	1,077,358	-749,101	328,257	10.00
11.00	01100	CAFETERIA	0	0	0	749,101	749,101	11.00
13.00	01300	NURSING ADMINISTRATION	146,327	56,108	202,435	0	202,435	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,369	1,046,913	1,090,282	0	1,090,282	14.00
15.00	01500	PHARMACY	655,535	2,229,801	2,885,336	-10,686	2,874,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	335,469	381,863	717,332	0	717,332	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,678,963	662,014	2,340,977	0	2,340,977	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	597,765	337,393	935,158	0	935,158	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	682,037	752,524	1,434,561	0	1,434,561	50.00
51.00	05100	RECOVERY ROOM	69,967	24,318	94,285	0	94,285	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	722,440	490,010	1,212,450	0	1,212,450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	713,726	1,291,815	2,005,541	0	2,005,541	54.00
56.00	05600	RADIOISOTOPE	85,732	133,179	218,911	0	218,911	56.00
60.00	06000	LABORATORY	733,035	1,261,571	1,994,606	0	1,994,606	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	109,058	109,058	0	109,058	63.00
66.00	06600	PHYSICAL THERAPY	864,100	442,720	1,306,820	0	1,306,820	66.00
69.00	06900	ELECTROCARDIOLOGY	523,228	301,929	825,157	0	825,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	724,212	724,212	0	724,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	134,596	134,596	0	134,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	179,571	179,571	0	179,571	90.00
90.01	09001	SENIOR CARE	132,826	136,520	269,346	0	269,346	90.01
91.00	09100	EMERGENCY	818,040	2,752,257	3,570,297	0	3,570,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	823,646	540,435	1,364,081	0	1,364,081	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	373,674	406,010	779,684	0	779,684	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,949,027	21,922,246	34,871,273	6	34,871,279	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,845,903	2,163,313	5,009,216	0	5,009,216	192.00
194.00	07950	FITNESS CENTER	28	13	41	-6	35	194.00
194.01	07951	MARKETING	63,093	120,185	183,278	0	183,278	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	88,849	44,714	133,563	0	133,563	194.04
200.00		TOTAL (SUM OF LINES 118-199)	15,946,900	24,250,471	40,197,371	0	40,197,371	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-43,895	351,679	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-451,787	756,112	2.00
4.00	00400	EMPLOYEE BENEFITS	-1,950	564,151	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	-343,883	3,890,336	5.01
5.02	00560	BUSINESS OFFICE	0	1,069,807	5.02
6.00	00600	MAINTENANCE & REPAIRS	-409	672,636	6.00
7.00	00700	OPERATION OF PLANT	-8,555	518,920	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	735,791	9.00
10.00	01000	DIETARY	0	328,257	10.00
11.00	01100	CAFETERIA	-229,954	519,147	11.00
13.00	01300	NURSING ADMINISTRATION	0	202,435	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,405	1,088,877	14.00
15.00	01500	PHARMACY	-113,299	2,761,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16,360	700,972	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-260,026	2,080,951	30.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	935,158	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,434,561	50.00
51.00	05100	RECOVERY ROOM	0	94,285	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,164,015	48,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-397	2,005,144	54.00
56.00	05600	RADIOISOTOPE	0	218,911	56.00
60.00	06000	LABORATORY	-14,735	1,979,871	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	109,058	63.00
66.00	06600	PHYSICAL THERAPY	0	1,306,820	66.00
69.00	06900	ELECTROCARDIOLOGY	-78,244	746,913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	724,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	134,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	179,571	90.00
90.01	09001	SENIOR CARE	0	269,346	90.01
91.00	09100	EMERGENCY	-1,458,691	2,111,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	1,364,081	101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0	779,684	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,187,605	30,683,674	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,009,216	192.00
194.00	07950	FITNESS CENTER	0	35	194.00
194.01	07951	MARKETING	0	183,278	194.01
194.02	07952	NEW DIRECTION	0	0	194.02
194.03	07953	RESPITE	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	133,563	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-4,187,605	36,009,766	200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet Non-CMS W | Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.01	OTHER ADMINISTRATIVE AND GENERAL	00561		5.01
5.02	BUSINESS OFFICE	00560		5.02
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
60.00	LABORATORY	06000		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
90.01	SENIOR CARE	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	FITNESS CENTER	07950		194.00
194.01	MARKETING	07951		194.01
194.02	NEW DIRECTION	07952		194.02
194.03	RESPITE	07953		194.03
194.04	WELL CHILD CLINIC	07954		194.04
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/29/2013 8:08 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	319,553	429,548		1.00
	TOTALS		319,553	429,548		
	B - TUMOR REGISTRY					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	10,686		1.00
	TOTALS		0	10,686		
	E - INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,916		1.00
	TOTALS		0	1,916		
	F - FITNESS CENTER					
1.00	EMPLOYEE BENEFITS	4.00	4	2		1.00
	TOTALS		4	2		
500.00	Grand Total: Increases		319,557	442,152		500.00

RECLASSIFICATIONS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/29/2013 8:08 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	319,553	429,548	0	1.00
	TOTALS		319,553	429,548		
	B - TUMOR REGISTRY					
1.00	PHARMACY	15.00	0	10,686	0	1.00
	TOTALS		0	10,686		
	E - INTEREST					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,916	9	1.00
	TOTALS		0	1,916		
	F - FITNESS CENTER					
1.00	FITNESS CENTER	194.00	4	2	0	1.00
	TOTALS		4	2		
500.00	Grand Total: Decreases		319,557	442,152		500.00

RECLASSIFICATIONS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/29/2013 8:08 am

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - CAFETERIA						
1.00	CAFETERIA	11.00	319,553	DIETARY	10.00	319,553	1.00
	TOTALS		319,553	TOTALS		319,553	
	B - TUMOR REGISTRY						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	PHARMACY	15.00	0	1.00
	TOTALS		0	TOTALS		0	
	E - INTEREST						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1.00
	TOTALS		0	TOTALS		0	
	F - FITNESS CENTER						
1.00	EMPLOYEE BENEFITS	4.00	4	FITNESS CENTER	194.00	4	1.00
	TOTALS		4	TOTALS		4	
500.00	Grand Total: Increases		319,557	Grand Total: Decreases		319,557	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2013 8:08 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	475,705	819,309	0	819,309	0	1.00
2.00	Land Improvements	314,699	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,236,782	972,015	0	972,015	0	3.00
4.00	Building Improvements	3,635,918	23,474	0	23,474	0	4.00
5.00	Fixed Equipment	845,994	0	0	0	0	5.00
6.00	Movable Equipment	12,008,261	466,118	0	466,118	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,517,359	2,280,916	0	2,280,916	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,517,359	2,280,916	0	2,280,916	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,295,014	0	1.00
2.00	Land Improvements	314,699	0	2.00
3.00	Buildings and Fixtures	15,208,797	0	3.00
4.00	Building Improvements	3,659,392	0	4.00
5.00	Fixed Equipment	845,994	0	5.00
6.00	Movable Equipment	12,474,379	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,798,275	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,798,275	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	395,574	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,205,983	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,601,557	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	395,574	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,205,983	2.00
3.00	Total (sum of lines 1-2)	0	1,601,557	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	395,574	0	395,574	0.246993	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,205,983	0	1,205,983	0.753007	0	2.00
3.00	Total (sum of lines 1-2)	1,601,557	0	1,601,557	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	351,679	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	756,112	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,107,791	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	351,679	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	756,112	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,107,791	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,916	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-3,408	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	B	-8,555	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,536,935			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-229,954	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,405	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients	B	-113,299	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-16,360	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-409	MAINTENANCE & REPAIRS	6.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DEVELOPMENT	A	-212,001	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	MISC REVENUE	B	-61,415	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	35.00
37.00	LAB FEES	B	-14,735	LABORATORY	60.00	0	37.00
38.00			0		0.00	0	38.00
40.00	ANESTHESIA	B	-1,164,015	ANESTHESIOLOGY	53.00	0	40.00
42.00	PHYSICIAN RECRUITING	A	-58,368	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00	LOBBYING	A	-8,691	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	43.00
44.00	PROPERTY TAXES	A	-43,895	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
45.01	FITNESS CENTER	B	-1,950	EMPLOYEE BENEFITS	4.00	0	45.01
45.02	MRI	B	-397	RADIOLOGY-DIAGNOSTIC	54.00	0	45.02
46.00	HOSPITALIST	A	-260,026	ADULTS & PEDIATRICS	30.00	0	46.00
46.01	EHR ASSET DEPRECIATION OFFSET	A	-449,871	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	46.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,187,605				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2013 8:08 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	69.00	ELECTROCARDIOLOGY	78,244	78,244	0	0	0	1.00
2.00	91.00	EMERGENCY	807,069	807,069	0	0	0	2.00
3.00	91.00	EMERGENCY	1,606,800	651,622	955,178	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,492,113	1,536,935	955,178		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	69.00	ELECTROCARDIOLOGY	0	0	0	78,244		1.00
2.00	91.00	EMERGENCY	0	0	0	807,069		2.00
3.00	91.00	EMERGENCY	0	0	0	651,622		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,536,935		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	351,679	351,679				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	756,112		756,112			2.00
4.00	00400	EMPLOYEE BENEFITS	564,151	8,289	7,203	579,643		4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	3,890,336	16,767	152,098	49,811	4,109,012	5.01
5.02	00560	BUSINESS OFFICE	1,069,807	5,184	5,624	14,279	1,094,894	5.02
6.00	00600	MAINTENANCE & REPAIRS	672,636	0	179,348	11,431	863,415	6.00
7.00	00700	OPERATION OF PLANT	518,920	71,237	0	0	590,157	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	735,791	5,346	0	10,570	751,707	9.00
10.00	01000	DIETARY	328,257	13,807	2,171	5,136	349,371	10.00
11.00	01100	CAFETERIA	519,147	4,282	0	11,720	535,149	11.00
13.00	01300	NURSING ADMINISTRATION	202,435	1,336	0	5,367	209,138	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,088,877	14,576	669	1,591	1,105,713	14.00
15.00	01500	PHARMACY	2,761,351	8,762	906	24,042	2,795,061	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	700,972	11,379	508	12,303	725,162	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,080,951	30,251	9,285	61,576	2,182,063	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	935,158	18,666	4,828	21,923	980,575	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,434,561	22,892	115,094	25,014	1,597,561	50.00
51.00	05100	RECOVERY ROOM	94,285	2,639	0	2,566	99,490	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	48,435	476	0	26,495	75,406	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,005,144	18,424	164,628	26,176	2,214,372	54.00
56.00	05600	RADIOISOTOPE	218,911	0	626	3,144	222,681	56.00
60.00	06000	LABORATORY	1,979,871	9,483	25,850	26,884	2,042,088	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	109,058	0	0	0	109,058	63.00
66.00	06600	PHYSICAL THERAPY	1,306,820	2,339	7,115	31,691	1,347,965	66.00
69.00	06900	ELECTROCARDIOLOGY	746,913	2,859	12,515	19,189	781,476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	724,212	0	0	0	724,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	134,596	0	0	0	134,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	179,571	2,709	10,465	0	192,745	90.00
90.01	09001	SENIOR CARE	269,346	5,722	0	4,871	279,939	90.01
91.00	09100	EMERGENCY	2,111,606	9,152	8,915	30,002	2,159,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,364,081	5,318	0	30,207	1,399,606	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	779,684	0	0	13,704	793,388	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,683,674	291,895	707,848	469,692	30,465,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,227	0	0	2,227	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,009,216	43,905	48,264	104,377	5,205,762	192.00
194.00	07950	FITNESS CENTER	35	9,297	0	1	9,333	194.00
194.01	07951	MARKETING	183,278	674	0	2,314	186,266	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	133,563	3,681	0	3,259	140,503	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	36,009,766	351,679	756,112	579,643	36,009,766	202.00

66.00
69.00
71.0
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COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	922,947					9.00
10.00	01000	DIETARY	52,044	558,860				10.00
11.00	01100	CAFETERIA	16,141	0	676,472			11.00
13.00	01300	NURSING ADMINISTRATION	5,038	0	7,081	267,863		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,940	0	3,649	0	1,462,316	14.00
15.00	01500	PHARMACY	33,027	0	32,115	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,892	0	30,814	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	114,026	179,853	87,783	98,846	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	70,357	247,306	52,561	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,289	65,993	46,276	52,109	0	50.00
51.00	05100	RECOVERY ROOM	9,949	0	3,540	3,986	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,795	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,444	10,801	50,213	56,542	0	54.00
56.00	05600	RADIOISOTOPE	0	0	4,950	0	0	56.00
60.00	06000	LABORATORY	35,745	30	53,862	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	8,816	1,294	45,192	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,778	5,957	35,402	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,462,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,912	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,211	2,452	0	0	0	90.00
90.01	09001	SENIOR CARE	21,567	6,574	7,874	0	0	90.01
91.00	09100	EMERGENCY	34,497	25,693	50,069	56,380	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	20,045	226	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	697,601	552,091	511,381	267,863	1,462,316	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,396	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	165,494	6,769	154,795	0	0	192.00
194.00	07950	FITNESS CENTER	35,042	0	0	0	0	194.00
194.01	07951	MARKETING	2,540	0	3,071	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	13,874	0	7,225	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	922,947	558,860	676,472	267,863	1,462,316	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,420,583					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,006,827				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	78,716	3,339,461	0	3,339,461	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	17,014	1,671,668	0	1,671,668	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,077	2,351,890	0	2,351,890	50.00
51.00	05100	RECOVERY ROOM	0	5,359	158,262	0	158,262	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	11,017	104,992	0	104,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	183,136	3,112,237	0	3,112,237	54.00
56.00	05600	RADIOISOTOPE	0	13,962	281,459	0	281,459	56.00
60.00	06000	LABORATORY	0	154,328	2,717,392	0	2,717,392	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,002	131,574	0	131,574	63.00
66.00	06600	PHYSICAL THERAPY	0	34,893	1,695,651	0	1,695,651	66.00
69.00	06900	ELECTROCARDIOLOGY	0	37,270	1,030,744	0	1,030,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58,256	2,374,372	0	2,374,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,827	169,507	0	169,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,420,583	241,531	3,668,026	0	3,668,026	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,521	269,343	0	269,343	90.00
90.01	09001	SENIOR CARE	0	6,564	411,922	0	411,922	90.01
91.00	09100	EMERGENCY	0	83,354	2,812,885	0	2,812,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,706,865	0	1,706,865	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	935,359	0	935,359	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,420,583	1,006,827	28,943,609	0	28,943,609	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	26,214	0	26,214	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,505,006	0	6,505,006	192.00
194.00	07950	FITNESS CENTER	0	0	109,450	0	109,450	194.00
194.01	07951	MARKETING	0	0	220,498	0	220,498	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	0	204,989	0	204,989	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,420,583	1,006,827	36,009,766	0	36,009,766	202.00

COST ALLOCATION STATISTICS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet Non-CMS W | Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS SALARIES	4.00
5.01	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.01
5.02	BUSINESS OFFICE	5	ACCUM. COST	5.02
6.00	MAINTENANCE & REPAIRS	3	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	3	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	3	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	HOURS	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS REV	16.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	8,289	7,203	15,492	15,492	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	0	16,767	152,098	168,865	1,331	5.01
5.02	00560	BUSINESS OFFICE	0	5,184	5,624	10,808	382	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	179,348	179,348	305	6.00
7.00	00700	OPERATION OF PLANT	0	71,237	0	71,237	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,346	0	5,346	282	9.00
10.00	01000	DIETARY	0	13,807	2,171	15,978	137	10.00
11.00	01100	CAFETERIA	0	4,282	0	4,282	313	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,336	0	1,336	143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,576	669	15,245	43	14.00
15.00	01500	PHARMACY	0	8,762	906	9,668	642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,379	508	11,887	329	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	30,251	9,285	39,536	1,645	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	18,666	4,828	23,494	586	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	22,892	115,094	137,986	668	50.00
51.00	05100	RECOVERY ROOM	0	2,639	0	2,639	69	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	476	0	476	708	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,424	164,628	183,052	699	54.00
56.00	05600	RADIOISOTOPE	0	0	626	626	84	56.00
60.00	06000	LABORATORY	0	9,483	25,850	35,333	718	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	2,339	7,115	9,454	847	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,859	12,515	15,374	513	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,709	10,465	13,174	0	90.00
90.01	09001	SENIOR CARE	0	5,722	0	5,722	130	90.01
91.00	09100	EMERGENCY	0	9,152	8,915	18,067	802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,318	0	5,318	807	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	366	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	291,895	707,848	999,743	12,549	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,227	0	2,227	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,905	48,264	92,169	2,794	192.00
194.00	07950	FITNESS CENTER	0	9,297	0	9,297	0	194.00
194.01	07951	MARKETING	0	674	0	674	62	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	3,681	0	3,681	87	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	351,679	756,112	1,107,791	15,492	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	170,196					5.01
5.02	00560	BUSINESS OFFICE	5,841	17,031				5.02
6.00	00600	MAINTENANCE & REPAIRS	4,606	670	184,929			6.00
7.00	00700	OPERATION OF PLANT	3,148	408	40,979	115,772		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	4,010	519	3,076	2,474	0	9.00
10.00	01000	DIETARY	1,864	242	7,944	6,389	0	10.00
11.00	01100	CAFETERIA	2,855	370	2,464	1,981	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,116	145	769	618	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,899	764	8,386	6,744	0	14.00
15.00	01500	PHARMACY	14,912	1,930	5,041	4,054	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,869	501	6,547	5,265	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,641	1,506	17,404	13,998	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,231	680	10,739	8,637	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,523	1,151	13,170	10,593	0	50.00
51.00	05100	RECOVERY ROOM	531	69	1,519	1,221	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	402	52	274	220	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,814	1,598	10,599	8,525	0	54.00
56.00	05600	RADIOISOTOPE	1,188	154	0	0	0	56.00
60.00	06000	LABORATORY	10,895	1,422	5,456	4,388	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	582	75	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	7,191	935	1,346	1,082	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,169	545	1,645	1,323	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,864	500	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	718	93	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,028	137	1,559	1,254	0	90.00
90.01	09001	SENIOR CARE	1,493	193	3,292	2,647	0	90.01
91.00	09100	EMERGENCY	11,522	857	5,265	4,235	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,467	967	3,060	2,461	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	4,233	548	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	140,612	17,031	150,534	88,109	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12	0	1,281	1,031	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,778	0	25,259	20,315	0	192.00
194.00	07950	FITNESS CENTER	50	0	5,349	4,302	0	194.00
194.01	07951	MARKETING	994	0	388	312	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	750	0	2,118	1,703	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	170,196	17,031	184,929	115,772	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,707					9.00
10.00	01000	DIETARY	886	33,440				10.00
11.00	01100	CAFETERIA	275	0	12,540			11.00
13.00	01300	NURSING ADMINISTRATION	86	0	131	4,344		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	935	0	68	0	38,084	14.00
15.00	01500	PHARMACY	562	0	595	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	730	0	571	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,941	10,762	1,627	1,603	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,197	14,798	974	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,468	3,949	858	845	0	50.00
51.00	05100	RECOVERY ROOM	169	0	66	65	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	31	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,182	646	931	917	0	54.00
56.00	05600	RADIOISOTOPE	0	0	92	0	0	56.00
60.00	06000	LABORATORY	608	2	998	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	150	77	838	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	183	356	656	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	38,084	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	354	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	174	147	0	0	0	90.00
90.01	09001	SENIOR CARE	367	393	146	0	0	90.01
91.00	09100	EMERGENCY	587	1,537	928	914	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	341	14	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,872	33,035	9,479	4,344	38,084	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	143	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,817	405	2,870	0	0	192.00
194.00	07950	FITNESS CENTER	596	0	0	0	0	194.00
194.01	07951	MARKETING	43	0	57	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	236	0	134	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,707	33,440	12,540	4,344	38,084	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	37,404					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,699				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,320	103,983	0	103,983	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	502	66,838	0	66,838	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,683	180,894	0	180,894	50.00
51.00	05100	RECOVERY ROOM	0	158	6,506	0	6,506	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	325	2,488	0	2,488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,398	225,361	0	225,361	54.00
56.00	05600	RADIOISOTOPE	0	412	2,556	0	2,556	56.00
60.00	06000	LABORATORY	0	4,549	64,369	0	64,369	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	88	745	0	745	63.00
66.00	06600	PHYSICAL THERAPY	0	1,029	22,949	0	22,949	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,099	25,863	0	25,863	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,717	44,165	0	44,165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	319	1,130	0	1,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,404	7,140	44,898	0	44,898	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	310	17,783	0	17,783	90.00
90.01	09001	SENIOR CARE	0	193	14,576	0	14,576	90.01
91.00	09100	EMERGENCY	0	2,457	47,171	0	47,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	20,435	0	20,435	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	5,147	0	5,147	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,404	29,699	897,857	0	897,857	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,694	0	4,694	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	174,407	0	174,407	192.00
194.00	07950	FITNESS CENTER	0	0	19,594	0	19,594	194.00
194.01	07951	MARKETING	0	0	2,530	0	2,530	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	0	8,709	0	8,709	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	37,404	29,699	1,107,791	0	1,107,791	202.00

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	126,309					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,298,970				2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	2,977	12,374	15,804,729			5.01
5.02	00560	BUSINESS OFFICE	6,022	261,298	1,358,183	-4,109,012	31,900,754	5.02
6.00	00600	MAINTENANCE & REPAIRS	1,862	9,662	389,335	0	1,094,894	6.00
7.00	00700	OPERATION OF PLANT	0	308,112	311,675	0	863,415	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,585	0	0	0	590,157	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	1,920	0	288,206	0	751,707	10.00
11.00	01100	CAFETERIA	4,959	3,729	140,029	0	349,371	11.00
13.00	01300	NURSING ADMINISTRATION	1,538	0	319,553	0	535,149	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	480	0	146,327	0	209,138	14.00
15.00	01500	PHARMACY	5,235	1,150	43,369	0	1,105,713	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,147	1,556	655,535	0	2,795,061	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS	4,087	873	335,469	0	725,162	30.00
30.00	03000	ADULTS & PEDIATRICS						43.00
43.00	04300	NURSERY	10,865	15,951	1,678,963	0	2,182,063	44.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	
		ANCILLARY SERVICE COST CENTERS	6,704	8,295	597,765	0	980,575	
50.00	05000	OPERATING ROOM						50.00
51.00	05100	RECOVERY ROOM	8,222	197,726	682,037	0	1,597,561	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	948	0	69,967	0	99,490	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171	0	722,440	0	75,406	54.00
56.00	05600	RADIOISOTOPE	6,617	282,825	713,726	0	2,214,372	56.00
60.00	06000	LABORATORY	0	1,076	85,732	0	222,681	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,406	44,410	733,035	0	2,042,088	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	109,058	66.00
69.00	06900	ELECTROCARDIOLOGY	840	12,223	864,100	0	1,347,965	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,027	21,501	523,228	0	781,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	724,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	134,596	73.00
		OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	
90.00	09000	CLINIC						90.00
90.01	09001	SENIOR CARE	973	17,979	0	0	192,745	90.01
91.00	09100	EMERGENCY	2,055	0	132,826	0	279,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,287	15,315	818,040	0	2,159,675	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,910	0	823,646	0	1,399,606	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	373,674	0	793,388	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	104,837	1,216,055	12,806,860	-4,109,012	26,356,663	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	0	0	2,227	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,769	82,915	2,845,903	0	5,205,762	192.00
194.00	07950	FITNESS CENTER	3,339	0	24	0	9,333	194.00
194.01	07951	MARKETING	242	0	63,093	0	186,266	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	1,322	0	88,849	0	140,503	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	351,679	756,112	579,643		4,109,012	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.784275	0.582086	0.036675		0.128806	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,492		170,196	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000980		0.005335	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	BUSINESS OFFICE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5.02	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE	24,654,255					5.02
6.00	00600	MAINTENANCE & REPAIRS	970,205	115,448				6.00
7.00	00700	OPERATION OF PLANT	590,157	25,585	89,863			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	155,759		8.00
9.00	00900	HOUSEKEEPING	751,785	1,920	1,920	44,110	87,943	9.00
10.00	01000	DIETARY	350,700	4,959	4,959	0	4,959	10.00
11.00	01100	CAFETERIA	535,235	1,538	1,538	0	1,538	11.00
13.00	01300	NURSING ADMINISTRATION	209,177	480	480	0	480	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,106,123	5,235	5,235	0	5,235	14.00
15.00	01500	PHARMACY	2,795,777	3,147	3,147	0	3,147	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	725,556	4,087	4,087	0	4,087	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,179,735	10,865	10,865	26,465	10,865	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	983,610	6,704	6,704	42,346	6,704	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,666,224	8,222	8,222	22,937	8,222	50.00
51.00	05100	RECOVERY ROOM	99,509	948	948	0	948	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	75,602	171	171	0	171	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,312,516	6,617	6,617	14,116	6,617	54.00
56.00	05600	RADIOISOTOPE	223,077	0	0	0	0	56.00
60.00	06000	LABORATORY	2,057,668	3,406	3,406	0	3,406	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	109,058	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,352,432	840	840	0	840	66.00
69.00	06900	ELECTROCARDIOLOGY	789,065	1,027	1,027	0	1,027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	724,212	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	134,596	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	198,972	973	973	0	973	90.00
90.01	09001	SENIOR CARE	279,975	2,055	2,055	0	2,055	90.01
91.00	09100	EMERGENCY	1,239,970	3,287	3,287	5,785	3,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,399,829	1,910	1,910	0	1,910	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	793,490	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,654,255	93,976	68,391	155,759	66,471	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	800	800	0	800	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,769	15,769	0	15,769	192.00
194.00	07950	FITNESS CENTER	0	3,339	3,339	0	3,339	194.00
194.01	07951	MARKETING	0	242	242	0	242	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	1,322	1,322	0	1,322	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,235,923	1,023,264	922,529	0	922,947	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.050130	8.863419	10.265949	0.000000	10.494832	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,031	184,929	115,772	0	15,707	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000691	1.601838	1.288317	0.000000	0.178604	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	37,151					10.00
11.00	01100	CAFETERIA	0	389,501				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,077	136,968			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,101	0	100		14.00
15.00	01500	PHARMACY	0	18,491	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,742	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,956	50,544	50,544	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,440	30,264	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,387	26,645	26,645	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,038	2,038	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	718	28,912	28,912	0	0	54.00
56.00	05600	RADIOISOTOPE	0	2,850	0	0	0	56.00
60.00	06000	LABORATORY	2	31,013	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	86	26,021	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	396	20,384	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	163	0	0	0	0	90.00
90.01	09001	SENIOR CARE	437	4,534	0	0	0	90.01
91.00	09100	EMERGENCY	1,708	28,829	28,829	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,701	294,445	136,968	100	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	450	89,128	0	0	0	192.00
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,768	0	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	4,160	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	558,860	676,472	267,863	1,462,316	3,420,583	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.042933	1.736766	1.955661	14,623.160000	34,205.830000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,440	12,540	4,344	38,084	37,404	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.900110	0.032195	0.031715	380.840000	374.040000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 8:08 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REV)										
			16.00										
		GENERAL SERVICE COST CENTERS											
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT											1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP											2.00
4.00	00400	EMPLOYEE BENEFITS											4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL											5.01
5.02	00560	BUSINESS OFFICE											5.02
6.00	00600	MAINTENANCE & REPAIRS											6.00
7.00	00700	OPERATION OF PLANT											7.00
8.00	00800	LAUNDRY & LINEN SERVICE											8.00
9.00	00900	HOUSEKEEPING											9.00
10.00	01000	DIETARY											10.00
11.00	01100	CAFETERIA											11.00
13.00	01300	NURSING ADMINISTRATION											13.00
14.00	01400	CENTRAL SERVICES & SUPPLY											14.00
15.00	01500	PHARMACY											15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,519,654										16.00
		INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	5,904,271										30.00
43.00	04300	NURSERY	0										43.00
44.00	04400	SKILLED NURSING FACILITY	1,276,174										44.00
		ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	4,281,230										50.00
51.00	05100	RECOVERY ROOM	401,977										51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0										52.00
53.00	05300	ANESTHESIOLOGY	826,351										53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,736,557										54.00
56.00	05600	RADIOISOTOPE	1,047,285										56.00
60.00	06000	LABORATORY	11,575,735										60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	225,174										63.00
66.00	06600	PHYSICAL THERAPY	2,617,261										66.00
69.00	06900	ELECTROCARDIOLOGY	2,795,546										69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,369,634										71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	812,106										72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,116,681										73.00
		OUTPATIENT SERVICE COST CENTERS											
90.00	09000	CLINIC	789,149										90.00
90.01	09001	SENIOR CARE	492,327										90.01
91.00	09100	EMERGENCY	6,252,196										91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)											92.00
		OTHER REIMBURSABLE COST CENTERS											
101.00	10100	HOME HEALTH AGENCY	0										101.00
		SPECIAL PURPOSE COST CENTERS											
116.00	11600	HOSPICE	0										116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,519,654										118.00
		NONREIMBURSABLE COST CENTERS											
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0										190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0										192.00
194.00	07950	FITNESS CENTER	0										194.00
194.01	07951	MARKETING	0										194.01
194.02	07952	NEW DIRECTION	0										194.02
194.03	07953	RESPITE	0										194.03
194.04	07954	WELL CHILD CLINIC	0										194.04
200.00		Cross Foot Adjustments											200.00
201.00		Negative Cost Centers											201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,006,827										202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013332										203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,699										204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000393										205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Charges Total Costs	Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,339,461		3,339,461	0	3,339,461	4,988,845	30.00
43.00	04300	NURSERY	0		0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,671,668		1,671,668	0	1,671,668	1,276,174	44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,351,890		2,351,890	0	2,351,890	484,828	50.00
51.00	05100	RECOVERY ROOM	158,262		158,262	0	158,262	71,778	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	104,992		104,992	0	104,992	107,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,112,237		3,112,237	0	3,112,237	774,146	54.00
56.00	05600	RADIOISOTOPE	281,459		281,459	0	281,459	24,473	56.00
60.00	06000	LABORATORY	2,717,392		2,717,392	0	2,717,392	1,597,188	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	131,574		131,574	0	131,574	79,502	63.00
66.00	06600	PHYSICAL THERAPY	1,695,651	0	1,695,651	0	1,695,651	483,342	66.00
69.00	06900	ELECTROCARDIOLOGY	1,030,744		1,030,744	0	1,030,744	814,811	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,374,372		2,374,372	0	2,374,372	2,332,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	169,507		169,507	0	169,507	453,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,668,026		3,668,026	0	3,668,026	4,164,147	73.00
		OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	269,343		269,343	0	269,343	0	90.00
90.01	09001	SENIOR CARE	411,922		411,922	0	411,922	0	90.01
91.00	09100	EMERGENCY	2,812,885		2,812,885	0	2,812,885	119,549	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	355,592		355,592		355,592	0	92.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,706,865		1,706,865		1,706,865	0	101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	935,359		935,359		935,359	0	116.00
200.00		Subtotal (see instructions)	29,299,201	0	29,299,201	0	29,299,201	17,772,622	200.00
201.00		Less Observation Beds	355,592		355,592		355,592		201.00
202.00		Total (see instructions)	28,943,609	0	28,943,609	0	28,943,609	17,772,622	202.00

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			7.00	8.00	9.00	10.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,988,845				30.00
43.00	04300	NURSERY		0				43.00
44.00	04400	SKILLED NURSING FACILITY		1,276,174				44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,796,402	4,281,230	0.549349	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	330,199	401,977	0.393709	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	719,001	826,351	0.127055	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,962,411	13,736,557	0.226566	0.000000	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,022,812	1,047,285	0.268751	0.000000	0.000000	56.00
60.00	06000	LABORATORY	9,978,547	11,575,735	0.234749	0.000000	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	145,672	225,174	0.584321	0.000000	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	2,133,919	2,617,261	0.647872	0.000000	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,470,441	2,285,252	0.451042	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,547,126	4,879,927	0.486559	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	358,419	812,107	0.208725	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,952,534	18,116,681	0.202467	0.000000	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	789,149	789,149	0.341308	0.000000	0.000000	90.00
90.01	09001	SENIOR CARE	492,327	492,327	0.836684	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	6,132,647	6,252,196	0.449904	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	915,426	915,426	0.388444	0.000000	0.000000	92.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,249,441	1,249,441					101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	1,220,593	1,220,593					116.00
200.00		Subtotal (see instructions)	60,217,066	77,989,688					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	60,217,066	77,989,688					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,339,461		3,339,461	0	3,339,461	4,988,845	30.00
43.00	04300	NURSERY	0		0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,671,668		1,671,668	0	1,671,668	1,276,174	44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,351,890		2,351,890	0	2,351,890	484,828	50.00
51.00	05100	RECOVERY ROOM	158,262		158,262	0	158,262	71,778	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	104,992		104,992	0	104,992	107,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,112,237		3,112,237	0	3,112,237	774,146	54.00
56.00	05600	RADIOISOTOPE	281,459		281,459	0	281,459	24,473	56.00
60.00	06000	LABORATORY	2,717,392		2,717,392	0	2,717,392	1,597,188	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	131,574		131,574	0	131,574	79,502	63.00
66.00	06600	PHYSICAL THERAPY	1,695,651	0	1,695,651	0	1,695,651	483,342	66.00
69.00	06900	ELECTROCARDIOLOGY	1,030,744		1,030,744	0	1,030,744	814,811	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,374,372		2,374,372	0	2,374,372	2,332,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	169,507		169,507	0	169,507	453,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,668,026		3,668,026	0	3,668,026	4,164,147	73.00
		OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	269,343		269,343	0	269,343	0	90.00
90.01	09001	SENIOR CARE	411,922		411,922	0	411,922	0	90.01
91.00	09100	EMERGENCY	2,812,885		2,812,885	0	2,812,885	119,549	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	355,592		355,592		355,592	0	92.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,706,865		1,706,865		1,706,865	0	101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	935,359		935,359		935,359	0	116.00
200.00		Subtotal (see instructions)	29,299,201	0	29,299,201	0	29,299,201	17,772,622	200.00
201.00		Less Observation Beds	355,592		355,592		355,592		201.00
202.00		Total (see instructions)	28,943,609	0	28,943,609	0	28,943,609	17,772,622	202.00

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		4,988,845					30.00
43.00	04300	NURSERY		0					43.00
44.00	04400	SKILLED NURSING FACILITY		1,276,174					44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,796,402	4,281,230	0.549349	0.000000	0.549349		50.00
51.00	05100	RECOVERY ROOM	330,199	401,977	0.393709	0.000000	0.393709		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	719,001	826,351	0.127055	0.000000	0.127055		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,962,411	13,736,557	0.226566	0.000000	0.226566		54.00
56.00	05600	RADIOISOTOPE	1,022,812	1,047,285	0.268751	0.000000	0.268751		56.00
60.00	06000	LABORATORY	9,978,547	11,575,735	0.234749	0.000000	0.234749		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	145,672	225,174	0.584321	0.000000	0.584321		63.00
66.00	06600	PHYSICAL THERAPY	2,133,919	2,617,261	0.647872	0.000000	0.647872		66.00
69.00	06900	ELECTROCARDIOLOGY	1,470,441	2,285,252	0.451042	0.000000	0.451042		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,547,126	4,879,927	0.486559	0.000000	0.486559		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	358,419	812,107	0.208725	0.000000	0.208725		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,952,534	18,116,681	0.202467	0.000000	0.202467		73.00
		OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	789,149	789,149	0.341308	0.000000	0.341308		90.00
90.01	09001	SENIOR CARE	492,327	492,327	0.836684	0.000000	0.836684		90.01
91.00	09100	EMERGENCY	6,132,647	6,252,196	0.449904	0.000000	0.449904		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	915,426	915,426	0.388444	0.000000	0.388444		92.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,249,441	1,249,441					101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	1,220,593	1,220,593					116.00
200.00		Subtotal (see instructions)	60,217,066	77,989,688					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	60,217,066	77,989,688					202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part II | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,351,890	180,894	2,170,996	0	0	50.00
51.00	05100	RECOVERY ROOM	158,262	6,506	151,756	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	104,992	2,488	102,504	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,112,237	225,361	2,886,876	0	0	54.00
56.00	05600	RADIOISOTOPE	281,459	2,556	278,903	0	0	56.00
60.00	06000	LABORATORY	2,717,392	64,369	2,653,023	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	131,574	745	130,829	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,695,651	22,949	1,672,702	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,030,744	25,863	1,004,881	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,374,372	44,165	2,330,207	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	169,507	1,130	168,377	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,668,026	44,898	3,623,128	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	269,343	17,783	251,560	0	0	90.00
90.01	09001	SENIOR CARE	411,922	14,576	397,346	0	0	90.01
91.00	09100	EMERGENCY	2,812,885	47,171	2,765,714	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	355,592	0	355,592	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,706,865	20,435	1,686,430	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	935,359	5,147	930,212	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	24,288,072	727,036	23,561,036	0	0	200.00
201.00		Less Observation Beds	355,592	0	355,592	0	0	201.00
202.00		Total (line 200 minus line 201)	23,932,480	727,036	23,205,444	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part II | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,351,890	4,281,230	0.549349		50.00
51.00	05100	RECOVERY ROOM	158,262	401,977	0.393709		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	104,992	826,351	0.127055		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,112,237	13,736,557	0.226566		54.00
56.00	05600	RADIOISOTOPE	281,459	1,047,285	0.268751		56.00
60.00	06000	LABORATORY	2,717,392	11,575,735	0.234749		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	131,574	225,174	0.584321		63.00
66.00	06600	PHYSICAL THERAPY	1,695,651	2,617,261	0.647872		66.00
69.00	06900	ELECTROCARDIOLOGY	1,030,744	2,285,252	0.451042		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,374,372	4,879,927	0.486559		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	169,507	812,107	0.208725		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,668,026	18,116,681	0.202467		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	269,343	789,149	0.341308		90.00
90.01	09001	SENIOR CARE	411,922	492,327	0.836684		90.01
91.00	09100	EMERGENCY	2,812,885	6,252,196	0.449904		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	355,592	915,426	0.388444		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,706,865	1,249,441	1.366103		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	935,359	1,220,593	0.766315		116.00
200.00		Subtotal (sum of lines 50 thru 199)	24,288,072	71,724,669			200.00
201.00		Less Observation Beds	355,592	0			201.00
202.00		Total (line 200 minus line 201)	23,932,480	71,724,669			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	180,894	4,281,230	0.042253	170,885	7,220	50.00
51.00	05100	RECOVERY ROOM	6,506	401,977	0.016185	25,367	411	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,488	826,351	0.003011	26,665	80	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	225,361	13,736,557	0.016406	359,451	5,897	54.00
56.00	05600	RADIOISOTOPE	2,556	1,047,285	0.002441	10,235	25	56.00
60.00	06000	LABORATORY	64,369	11,575,735	0.005561	754,962	4,198	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	745	225,174	0.003309	73,323	243	63.00
66.00	06600	PHYSICAL THERAPY	22,949	2,617,261	0.008768	83,718	734	66.00
69.00	06900	ELECTROCARDIOLOGY	25,863	2,285,252	0.011317	400,678	4,534	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,165	4,879,927	0.009050	704,899	6,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,130	812,107	0.001391	111,403	155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,898	18,116,681	0.002478	2,153,570	5,337	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17,783	789,149	0.022534	0	0	90.00
90.01	09001	SENIOR CARE	14,576	492,327	0.029606	0	0	90.01
91.00	09100	EMERGENCY	47,171	6,252,196	0.007545	2,535	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	915,426	0.000000	0	0	92.00
200.00		Total (lines 50-199)	701,454	69,254,635		4,877,691	35,232	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,281,230	0.000000	0.000000	170,885	50.00
51.00	05100	RECOVERY ROOM	0	401,977	0.000000	0.000000	25,367	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	826,351	0.000000	0.000000	26,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,736,557	0.000000	0.000000	359,451	54.00
56.00	05600	RADIOISOTOPE	0	1,047,285	0.000000	0.000000	10,235	56.00
60.00	06000	LABORATORY	0	11,575,735	0.000000	0.000000	754,962	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	225,174	0.000000	0.000000	73,323	63.00
66.00	06600	PHYSICAL THERAPY	0	2,617,261	0.000000	0.000000	83,718	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,285,252	0.000000	0.000000	400,678	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,879,927	0.000000	0.000000	704,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	812,107	0.000000	0.000000	111,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,116,681	0.000000	0.000000	2,153,570	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	789,149	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	492,327	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,252,196	0.000000	0.000000	2,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	915,426	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	69,254,635			4,877,691	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.549349	0	915,831	0	0	50.00
51.00	05100	RECOVERY ROOM	0.393709	0	73,876	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.127055	0	118,454	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226566	0	4,153,805	0	0	54.00
56.00	05600	RADIOISOTOPE	0.268751	0	412,652	0	0	56.00
60.00	06000	LABORATORY	0.234749	0	3,683,779	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.584321	0	142,996	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.647872	0	598,859	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.451042	0	624,066	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486559	0	563,561	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.208725	0	71,164	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202467	0	5,717,171	143	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.341308	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.836684	0	408,174	0	0	90.01
91.00	09100	EMERGENCY	0.449904	0	1,243,678	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388444	0	122,575	0	0	92.00
200.00		Subtotal (see instructions)		0	18,850,641	143	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	18,850,641	143	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	503,111	0	50.00
51.00	05100	RECOVERY ROOM	29,086	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,050	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	941,111	0	54.00
56.00	05600	RADIOISOTOPE	110,901	0	56.00
60.00	06000	LABORATORY	864,763	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	83,556	0	63.00
66.00	06600	PHYSICAL THERAPY	387,984	0	66.00
69.00	06900	ELECTROCARDIOLOGY	281,480	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	274,206	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,854	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,157,538	29	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	341,513	0	90.01
91.00	09100	EMERGENCY	559,536	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	47,614	0	92.00
200.00		Subtotal (see instructions)	5,612,303	29	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,612,303	29	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Component CCN: 15Z310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.549349	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.393709	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.127055	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226566	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.268751	0	0	0	0	56.00
60.00	06000	LABORATORY	0.234749	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.584321	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.647872	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.451042	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486559	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.208725	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202467	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.341308	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.836684	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.449904	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388444	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/29/2013 8:08 am

Component CCN: 15Z310 | Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Component CCN: 155365 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Component CCN: 155365 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,281,230	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	401,977	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	826,351	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,736,557	0.000000	0.000000	13,959	54.00
56.00	05600	RADIOISOTOPE	0	1,047,285	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	11,575,735	0.000000	0.000000	33,306	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	225,174	0.000000	0.000000	411	63.00
66.00	06600	PHYSICAL THERAPY	0	2,617,261	0.000000	0.000000	164,808	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,285,252	0.000000	0.000000	41,946	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,879,927	0.000000	0.000000	1,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	812,107	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,116,681	0.000000	0.000000	190,596	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	789,149	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	492,327	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,252,196	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	915,426	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	69,254,635			446,710	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Component CCN: 155365 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Component CCN: 155365 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part I Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	103,983	7,025	96,958	2,557	37.92	30.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	66,838		66,838	4,205	15.89	44.00
200.00	Total (lines 30-199)	170,821		163,796	6,762		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	64	2,427	30.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	64	2,427	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	180,894	4,281,230	0.042253	24,692	1,043	50.00
51.00	05100	RECOVERY ROOM	6,506	401,977	0.016185	3,893	63	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,488	826,351	0.003011	4,845	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	225,361	13,736,557	0.016406	34,129	560	54.00
56.00	05600	RADIOISOTOPE	2,556	1,047,285	0.002441	0	0	56.00
60.00	06000	LABORATORY	64,369	11,575,735	0.005561	49,879	277	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	745	225,174	0.003309	123	0	63.00
66.00	06600	PHYSICAL THERAPY	22,949	2,617,261	0.008768	6,704	59	66.00
69.00	06900	ELECTROCARDIOLOGY	25,863	2,285,252	0.011317	30,576	346	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,165	4,879,927	0.009050	120,579	1,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,130	812,107	0.001391	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,898	18,116,681	0.002478	117,941	292	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17,783	789,149	0.022534	0	0	90.00
90.01	09001	SENIOR CARE	14,576	492,327	0.029606	0	0	90.01
91.00	09100	EMERGENCY	47,171	6,252,196	0.007545	16,527	125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,875	915,426	0.012972	0	0	92.00
200.00		Total (lines 50-199)	713,329	69,254,635		409,888	3,871	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part III Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,557	0.00	64	0	0	30.00
43.00	04300	NURSERY	0	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,205	0.00	0	0	0	44.00
200.00		Total (lines 30-199)	6,762		64	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
			12.00	13.00	
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,281,230	0.000000	0.000000	24,692	50.00
51.00	05100	RECOVERY ROOM	0	401,977	0.000000	0.000000	3,893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	826,351	0.000000	0.000000	4,845	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,736,557	0.000000	0.000000	34,129	54.00
56.00	05600	RADIOISOTOPE	0	1,047,285	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	11,575,735	0.000000	0.000000	49,879	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	225,174	0.000000	0.000000	123	63.00
66.00	06600	PHYSICAL THERAPY	0	2,617,261	0.000000	0.000000	6,704	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,285,252	0.000000	0.000000	30,576	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,879,927	0.000000	0.000000	120,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	812,107	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,116,681	0.000000	0.000000	117,941	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	789,149	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	492,327	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,252,196	0.000000	0.000000	16,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	915,426	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	69,254,635			409,888	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.549349	0	0	226,514	0	50.00
51.00	05100	RECOVERY ROOM	0.393709	0	0	32,424	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.127055	0	0	48,638	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226566	0	0	1,144,409	0	54.00
56.00	05600	RADIOISOTOPE	0.268751	0	0	48,338	0	56.00
60.00	06000	LABORATORY	0.234749	0	0	854,461	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.584321	0	0	1,233	0	63.00
66.00	06600	PHYSICAL THERAPY	0.647872	0	0	97,291	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.451042	0	0	53,767	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486559	0	0	247,366	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.208725	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202467	0	0	850,026	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.341308	0	0	65,318	0	90.00
90.01	09001	SENIOR CARE	0.836684	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.449904	0	0	1,137,700	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388444	0	0	28,624	0	92.00
200.00		Subtotal (see instructions)		0	0	4,836,109	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	4,836,109	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	124,435	50.00
51.00	05100	RECOVERY ROOM	0	12,766	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	6,180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	259,284	54.00
56.00	05600	RADIOISOTOPE	0	12,991	56.00
60.00	06000	LABORATORY	0	200,584	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	720	63.00
66.00	06600	PHYSICAL THERAPY	0	63,032	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24,251	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	120,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	172,102	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	22,294	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	511,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,119	92.00
200.00		Subtotal (see instructions)	0	1,541,972	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,541,972	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,802	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,557	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,265	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	178	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	67	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,202	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	178	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,339,461	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	8,844	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	225,609	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,113,852	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,988,845	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,988,845	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.624163	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,202.58	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,113,852	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,217.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,463,772	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,463,772	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,449,870	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,913,642	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	216,765	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	216,765	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	292	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,217.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	355,592	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310	Period: From 01/01/2012	Worksheet D-1
Component CCN: 155365	To 12/31/2012	Date/Time Prepared: 5/29/2013 8:08 am
Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,205	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,205	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,205	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	245	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	67	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	835	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	178	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,671,668	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	8,844	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	100,393	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,571,275	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,276,174	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,276,174	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.231239	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	303.49	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,571,275	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Component CCN: 155365 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	1,571,275	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	373.67	71.00
72.00	Program routine service cost (line 9 x line 71)	312,014	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	312,014	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	312,014	83.00
84.00	Program inpatient ancillary services (see instructions)	176,323	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	488,337	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1

Component CCN: 155365 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,802	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,557	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,265	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		178	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		67	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		64	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		67	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,339,461	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		8,844	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		225,609	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,113,852	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,988,845	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,988,845	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.624163	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,202.58	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,113,852	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,217.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		77,938	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		77,938	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	143,345	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	221,283	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,427	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,871	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	6,298	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	214,985	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	8,844	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	8,844	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	292	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,217.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	355,592	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	103,983	3,113,852	0.033394	355,592	11,875	90.00
91.00	Nursing School cost	0	3,113,852	0.000000	355,592	0	91.00
92.00	Allied health cost	0	3,113,852	0.000000	355,592	0	92.00
93.00	All other Medical Education	0	3,113,852	0.000000	355,592	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,371,779		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.549349	170,885	93,876	50.00
51.00	05100	RECOVERY ROOM	0.393709	25,367	9,987	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.127055	26,665	3,388	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226566	359,451	81,439	54.00
56.00	05600	RADIOISOTOPE	0.268751	10,235	2,751	56.00
60.00	06000	LABORATORY	0.234749	754,962	177,227	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.584321	73,323	42,844	63.00
66.00	06600	PHYSICAL THERAPY	0.647872	83,718	54,239	66.00
69.00	06900	ELECTROCARDIOLOGY	0.451042	400,678	180,723	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486559	704,899	342,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.208725	111,403	23,253	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202467	2,153,570	436,027	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.341308	0	0	90.00
90.01	09001	SENIOR CARE	0.836684	0	0	90.01
91.00	09100	EMERGENCY	0.449904	2,535	1,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388444	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,877,691	1,449,870	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,877,691		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3

Component CCN: 152310 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.549349	0	0	50.00
51.00	05100	RECOVERY ROOM	0.393709	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.127055	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226566	7,762	1,759	54.00
56.00	05600	RADIOISOTOPE	0.268751	0	0	56.00
60.00	06000	LABORATORY	0.234749	37,880	8,892	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.584321	4,860	2,840	63.00
66.00	06600	PHYSICAL THERAPY	0.647872	29,893	19,367	66.00
69.00	06900	ELECTROCARDIOLOGY	0.451042	22,796	10,282	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486559	3,547	1,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.208725	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202467	218,730	44,286	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.341308	0	0	90.00
90.01	09001	SENIOR CARE	0.836684	0	0	90.01
91.00	09100	EMERGENCY	0.449904	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388444	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		325,468	89,152	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		325,468		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3
Component CCN: 155365 | Date/Time Prepared: 5/29/2013 8:08 am
Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.549349	0	0	50.00
51.00	05100	RECOVERY ROOM	0.393709	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.127055	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226566	13,959	3,163	54.00
56.00	05600	RADIOISOTOPE	0.268751	0	0	56.00
60.00	06000	LABORATORY	0.234749	33,306	7,819	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.584321	411	240	63.00
66.00	06600	PHYSICAL THERAPY	0.647872	164,808	106,774	66.00
69.00	06900	ELECTROCARDIOLOGY	0.451042	41,946	18,919	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486559	1,684	819	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.208725	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202467	190,596	38,589	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.341308	0	0	90.00
90.01	09001	SENIOR CARE	0.836684	0	0	90.01
91.00	09100	EMERGENCY	0.449904	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388444	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		446,710	176,323	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		446,710		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/29/2013 8:08 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		141,852		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.549349	24,692	13,565	50.00
51.00	05100	RECOVERY ROOM	0.393709	3,893	1,533	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.127055	4,845	616	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226566	34,129	7,732	54.00
56.00	05600	RADIOISOTOPE	0.268751	0	0	56.00
60.00	06000	LABORATORY	0.234749	49,879	11,709	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.584321	123	72	63.00
66.00	06600	PHYSICAL THERAPY	0.647872	6,704	4,343	66.00
69.00	06900	ELECTROCARDIOLOGY	0.451042	30,576	13,791	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486559	120,579	58,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.208725	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202467	117,941	23,879	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.341308	0	0	90.00
90.01	09001	SENIOR CARE	0.836684	0	0	90.01
91.00	09100	EMERGENCY	0.449904	16,527	7,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.388444	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		409,888	143,345	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		409,888		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E Part B Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,612,332	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,612,332	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,668,455	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	18,650	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,017,867	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,631,938	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,631,938	30.00
31.00	Primary payer payments	1,503	31.00
32.00	Subtotal (line 30 minus line 31)	2,630,435	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	385,866	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	385,866	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,016,301	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	3,016,301	40.00
41.00	Interim payments	3,371,252	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	-354,951	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,665,059		3,371,252	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/01/2012	270,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		270,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,935,959		3,371,252	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		261,932		354,951	6.02
7.00	Total Medicare program liability (see instructions)		2,674,027		3,016,301	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151310 | Component CCN: 15Z310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		297,929		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/01/2012	34,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		34,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		332,829		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		28,332		0	6.02
7.00	Total Medicare program liability (see instructions)		304,497		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151310 | Component CCN: 155365 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		205,361		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		205,361		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		205,361		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part II | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	672	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,202	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	445	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,265	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	77,989,688	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,915,383	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	1,017,880	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	962,493	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	872,527	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	89,966	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151310 | Component CCN: 15Z310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-2 | Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	218,933	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	90,044	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days			
6.00	Interns and residents not in approved teaching program (see instructions)	178	0	5.00
7.00	Utilization review - physician compensation - SNF optional method only		0	6.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		7.00
9.00	Primary payer payments (see instructions)	308,977	0	8.00
10.00	Subtotal (line 8 minus line 9)	0	0	9.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	308,977	0	10.00
12.00	Subtotal (line 10 minus line 11)	0	0	11.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	308,977	0	12.00
14.00	80% of Part B costs (line 12 x 80%)	4,480	0	13.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	14.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	304,497	0	15.00
17.00	Reimbursable bad debts (see instructions)	0	0	16.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	17.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	0	0	18.00
20.00	Interim payments	304,497	0	19.00
21.00	Tentative settlement (for contractor use only)	332,829	0	20.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	0	0	21.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	-28,332	0	22.00
		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-3 Part V Date/Time Prepared: 5/29/2013 8:08 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,913,642	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,913,642	4.00
5.00	Primary payer payments	3,387	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,939,391	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,939,391	19.00
20.00	Deductibles (exclude professional component)	286,688	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,652,703	22.00
23.00	Coinsurance	289	23.00
24.00	Subtotal (line 22 minus line 23)	2,652,414	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,613	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	21,613	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,674,027	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,674,027	30.00
31.00	Interim payments	2,935,959	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	-261,932	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151310 Component CCN: 155365	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2013 8:08 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	240,619	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	240,619	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	35,258	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	205,361	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	205,361	15.00
16.00	Interim payments	205,361	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G | Date/Time Prepared: 5/29/2013 8:08 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,359,963	0	0	0	1.00
2.00	Temporary investments	6,085,124	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,291,692	0	0	0	4.00
5.00	Other receivable	529,026	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,137,627	0	0	0	6.00
7.00	Inventory	923,845	0	0	0	7.00
8.00	Prepaid expenses	200,636	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,252,659	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	33,798,275	0	0	0	15.00
16.00	Accumulated depreciation	-26,256,602	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,541,673	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,479,913	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,479,913	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,274,245	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,085,267	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,611,387	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	360,503	0	0	0	43.00
44.00	Other current liabilities	446,263	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,503,420	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	115,621	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	115,621	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,619,041	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,655,204				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	29,655,204	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,274,245	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-1 | Date/Time Prepared: 5/29/2013 8:08 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,774,509		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		545,606				2.00
3.00	Total (sum of line 1 and line 2)		29,320,115		0		3.00
4.00	Additions (credit adjustments) (specify)	335,089		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		335,089		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,655,204		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,655,204		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,988,845		4,988,845	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,276,174		1,276,174	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,265,019		6,265,019	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,265,019		6,265,019	17.00
18.00	Ancillary services	11,506,548	57,748,084	69,254,632	18.00
19.00	Outpatient services	5,040	122,093	127,133	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,249,441	1,249,441	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,220,593	1,220,593	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,776,607	60,340,211	78,116,818	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,197,371		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	7,829,512			37.00
38.00		88,195			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		7,917,707		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,279,664		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-3 | Date/Time Prepared: 5/29/2013 8:08 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	78,116,818	1.00
2.00	Less contractual allowances and discounts on patients' accounts	43,053,264	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,063,554	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,279,664	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,783,890	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	1,116,586	24.00
25.00	Total other income (sum of lines 6-24)	1,116,586	25.00
26.00	Total (line 5 plus line 25)	3,900,476	26.00
27.00	OTHER EXPENSES (SPECIFY)	3,354,870	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,354,870	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	545,606	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H

HHA CCN: 157061 | Date/Time Prepared: 5/29/2013 8:08 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	116,025	0	500	0	89,319	205,844	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	243,070	356,469	22,273	0	19,504	641,316	6.00
7.00	Physical Therapy	190,575	0	13,816	0	0	204,391	7.00
8.00	Occupational Therapy	32,181	0	3,423	0	0	35,604	8.00
9.00	Speech Pathology	8,689	0	1,688	0	0	10,377	9.00
10.00	Medical Social Services	317	0	149	0	0	466	10.00
11.00	Home Health Aide	186,452	0	24,971	0	0	211,423	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	45,911	0	8,323	0	0	54,234	22.00
23.00	All Others (specify)	426	0	0	0	0	426	23.00
24.00	Total (sum of lines 1-23)	823,646	356,469	75,143	0	108,823	1,364,081	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	205,844	0	205,844			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	641,316	0	641,316			6.00
7.00	Physical Therapy	0	204,391	0	204,391			7.00
8.00	Occupational Therapy	0	35,604	0	35,604			8.00
9.00	Speech Pathology	0	10,377	0	10,377			9.00
10.00	Medical Social Services	0	466	0	466			10.00
11.00	Home Health Aide	0	211,423	0	211,423			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	54,234	0	54,234			22.00
23.00	All Others (specify)	0	426	0	426			23.00
24.00	Total (sum of lines 1-23)	0	1,364,081	0	1,364,081			24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151310 | HHA CCN: 157061 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-1 Part I | Date/Time Prepared: 5/29/2013 8:08 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	205,844	0	0	0	0	205,844	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	641,316	0	0	0	0	641,316	6.00
7.00	Physical Therapy	204,391	0	0	0	0	204,391	7.00
8.00	Occupational Therapy	35,604	0	0	0	0	35,604	8.00
9.00	Speech Pathology	10,377	0	0	0	0	10,377	9.00
10.00	Medical Social Services	466	0	0	0	0	466	10.00
11.00	Home Health Aide	211,423	0	0	0	0	211,423	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	54,234	0	0	0	0	54,234	22.00
23.00	All Others (specify)	426	0	0	0	0	426	23.00
24.00	Total (sum of lines 1-23)	1,364,081	0	0	0	0	1,364,081	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	205,844		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	113,974	755,290	6.00
7.00	Physical Therapy	36,325	240,716	7.00
8.00	Occupational Therapy	6,328	41,932	8.00
9.00	Speech Pathology	1,844	12,221	9.00
10.00	Medical Social Services	83	549	10.00
11.00	Home Health Aide	37,575	248,998	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	9,639	63,873	22.00
23.00	All Others (specify)	76	502	23.00
24.00	Total (sum of lines 1-23)		1,364,081	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151310 HHA CCN: 157061

Period: From 01/01/2012 To 12/31/2012

Worksheet H-1 Part II Date/Time Prepared: 5/29/2013 8:08 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-205,844	1,158,237	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	641,316	6.00
7.00	Physical Therapy	0	0	0	0	0	204,391	7.00
8.00	Occupational Therapy	0	0	0	0	0	35,604	8.00
9.00	Speech Pathology	0	0	0	0	0	10,377	9.00
10.00	Medical Social Services	0	0	0	0	0	466	10.00
11.00	Home Health Aide	0	0	0	0	0	211,423	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	54,234	22.00
23.00	All Others (specify)	0	0	0	0	0	426	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-205,844	1,158,237	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		205,844	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.177722	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2013 8:08 am

HHA CCN: 157061 | Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	5,318	0	30,207	35,525	4,576	1.00
2.00	Skilled Nursing Care	755,290	0	0	0	755,290	97,286	2.00
3.00	Physical Therapy	240,716	0	0	0	240,716	31,006	3.00
4.00	Occupational Therapy	41,932	0	0	0	41,932	5,401	4.00
5.00	Speech Pathology	12,221	0	0	0	12,221	1,574	5.00
6.00	Medical Social Services	549	0	0	0	549	71	6.00
7.00	Home Health Aide	248,998	0	0	0	248,998	32,072	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	63,873	0	0	0	63,873	8,227	18.00
19.00	All Others (specify)	502	0	0	0	502	65	19.00
20.00	Total (sum of lines 1-19) (2)	1,364,081	5,318	0	30,207	1,399,606	180,278	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.02	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	1,792	16,929	19,608	0	20,045	226	1.00
2.00	Skilled Nursing Care	37,862	0	0	0	0	0	2.00
3.00	Physical Therapy	12,067	0	0	0	0	0	3.00
4.00	Occupational Therapy	2,102	0	0	0	0	0	4.00
5.00	Speech Pathology	613	0	0	0	0	0	5.00
6.00	Medical Social Services	28	0	0	0	0	0	6.00
7.00	Home Health Aide	12,482	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	3,202	0	0	0	0	0	18.00
19.00	All Others (specify)	25	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	70,173	16,929	19,608	0	20,045	226	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151310 HHA CCN: 157061 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-2 Part I Date/Time Prepared: 5/29/2013 8:08 am

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	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	0	0	0	0	98,701	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	890,438	2.00
3.00	Physical Therapy	0	0	0	0	0	283,789	3.00
4.00	Occupational Therapy	0	0	0	0	0	49,435	4.00
5.00	Speech Pathology	0	0	0	0	0	14,408	5.00
6.00	Medical Social Services	0	0	0	0	0	648	6.00
7.00	Home Health Aide	0	0	0	0	0	293,552	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	75,302	18.00
19.00	All Others (specify)	0	0	0	0	0	592	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,706,865	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General	0	98,701				1.00
2.00	Skilled Nursing Care	0	890,438	54,650	945,088		2.00
3.00	Physical Therapy	0	283,789	17,418	301,207		3.00
4.00	Occupational Therapy	0	49,435	3,034	52,469		4.00
5.00	Speech Pathology	0	14,408	884	15,292		5.00
6.00	Medical Social Services	0	648	40	688		6.00
7.00	Home Health Aide	0	293,552	18,017	311,569		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	75,302	4,622	79,924		18.00
19.00	All Others (specify)	0	592	36	628		19.00
20.00	Total (sum of lines 1-19) (2)	0	1,706,865	98,701	1,706,865		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.061375			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151310 HHA CCN: 157061

Period: From 01/01/2012 To 12/31/2012

Worksheet H-2 Part II Date/Time Prepared: 5/29/2013 8:08 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	BUSINESS OFFICE (ACCUM. COST)	
		1.00	2.00	4.00	5A.01	5.01	5.02	
1.00	Administrative and General	1,910	0	823,646	0	35,525	35,748	1.00
2.00	Skilled Nursing Care	0	0	0	0	755,290	755,290	2.00
3.00	Physical Therapy	0	0	0	0	240,716	240,716	3.00
4.00	Occupational Therapy	0	0	0	0	41,932	41,932	4.00
5.00	Speech Pathology	0	0	0	0	12,221	12,221	5.00
6.00	Medical Social Services	0	0	0	0	549	549	6.00
7.00	Home Health Aide	0	0	0	0	248,998	248,998	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	63,873	63,873	18.00
19.00	All Others (specify)	0	0	0	0	502	502	19.00
20.00	Total (sum of lines 1-19)	1,910	0	823,646		1,399,606	1,399,829	20.00
21.00	Total cost to be allocated	5,318	0	30,207		180,278	70,173	21.00
22.00	Unit cost multiplier	2.784293	0.000000	0.036675		0.128806	0.050130	22.00

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,910	1,910	0	1,910	15	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,910	1,910	0	1,910	15	0	20.00
21.00	Total cost to be allocated	16,929	19,608	0	20,045	226	0	21.00
22.00	Unit cost multiplier	8.863351	10.265969	0.000000	10.494764	15.066667	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151310 | HHA CCN: 157061 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-2 Part II | Date/Time Prepared: 5/29/2013 8:08 am

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	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)			
		13.00	14.00	15.00	16.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2013 8:08 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	945,088		945,088	3,804	248.45	1.00
2.00	Physical Therapy	3.00	301,207	0	301,207	2,208	136.42	2.00
3.00	Occupational Therapy	4.00	52,469	0	52,469	475	110.46	3.00
4.00	Speech Pathology	5.00	15,292	0	15,292	95	160.97	4.00
5.00	Medical Social Services	6.00	688		688	16	43.00	5.00
6.00	Home Health Aide	7.00	311,569		311,569	7,449	41.83	6.00
7.00	Total (sum of lines 1-6)		1,626,313	0	1,626,313	14,047		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		15999	481	474			8.00
9.00	Physical Therapy		15999	581	535			9.00
10.00	Occupational Therapy		15999	129	89			10.00
11.00	Speech Pathology		15999	8	14			11.00
12.00	Medical Social Services		15999	3	4			12.00
13.00	Home Health Aide		15999	130	482			13.00
14.00	Total (sum of lines 8-13)			1,332	1,598			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	2,080	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	481	474		119,504	117,765		1.00
2.00	Physical Therapy	581	535		79,260	72,985		2.00
3.00	Occupational Therapy	129	89		14,249	9,831		3.00
4.00	Speech Pathology	8	14		1,288	2,254		4.00
5.00	Medical Social Services	3	4		129	172		5.00
6.00	Home Health Aide	130	482		5,438	20,162		6.00
7.00	Total (sum of lines 1-6)	1,332	1,598		219,868	223,169		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2013 8:08 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies		2,080	0		0	0	15.00
16.00	Cost of Drugs							16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)
		12.00
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION	
	Cost Per Visit Computation	
1.00	Skilled Nursing Care	237,269
2.00	Physical Therapy	152,245
3.00	Occupational Therapy	24,080
4.00	Speech Pathology	3,542
5.00	Medical Social Services	301
6.00	Home Health Aide	25,600
7.00	Total (sum of lines 1-6)	443,037
	Cost Center Description	
		12.00
	Limitation Cost Computation	
8.00	Skilled Nursing Care	
9.00	Physical Therapy	
10.00	Occupational Therapy	
11.00	Speech Pathology	
12.00	Medical Social Services	
13.00	Home Health Aide	
14.00	Total (sum of lines 8-13)	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310 HHA CCN: 157061 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-3 Part II Date/Time Prepared: 5/29/2013 8:08 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.647872	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.486559	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.202467	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151310 | HHA CCN: 157061 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2013 8:08 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	216,484	235,465	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	2,189	4,501	13.00
14.00	Total PPS Reimbursement - PEP Episodes	5,288	388	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	223,961	240,354	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	223,961	240,354	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	223,961	240,354	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151310 HHA CCN: 157061 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2013 8:08 am

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		Part A Services	Part B Services	
		1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	223,961	240,354	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	223,961	240,354	31.00
32.00	Interim payments (see instructions)	223,961	240,354	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-5

HHA CCN: 157061 | Date/Time Prepared: 5/29/2013 8:08 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		223,961		240,354	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50						
3.51			0		0	3.50
3.52			0		0	3.51
3.53			0		0	3.52
3.54			0		0	3.53
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.54
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		223,961		240,354	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50						
5.51			0		0	5.50
5.52			0		0	5.51
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.52
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		223,961		240,354	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151310
HHA CCN: 157061

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-5

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				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	373,674	162,006	30,300	0	36,624	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	30,000	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	89,357	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	56,708	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	1,015	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	373,674	162,006	30,300	0	213,704	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	602,604	0	602,604	0	602,604	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	30,000	0	30,000	0	30,000	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	89,357	0	89,357	0	89,357	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	56,708	0	56,708	0	56,708	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	1,015	0	1,015	0	1,015	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	779,684	0	779,684	0	779,684	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-1 | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-1 | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	373,674	373,674		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	373,674	373,674		39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-2 | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-2 | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	162,006	162,006		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation						27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	162,006	162,006		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-4 Part I | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST: BUILDINGS & FIXTURES	CAPITAL RELATED COST: MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	602,604	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	30,000	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	89,357	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	56,708	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	1,015	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	779,684	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-4 Part I | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	602,604	602,604			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	30,000	102,090	132,090		9.00
10.00	Nursing Care	0	0	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	89,357	304,082	393,439		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	56,708	192,978	249,686		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	1,015	3,454	4,469		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	779,684		779,684		39.00

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-4 Part II | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-602,604	177,080		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	30,000		9.00
10.00	Nursing Care	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	89,357		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	56,708		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	1,015		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		602,604		39.00
40.00	Unit Cost Multiplier		3.403004		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310
Hospice CCN: 151545

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part I
Date/Time Prepared:
5/29/2013 8:08 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	0	13,704	13,704	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	132,090	0	0	0	132,090	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	393,439	0	0	0	393,439	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	249,686	0	0	0	249,686	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	4,469	0	0	0	4,469	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	779,684	0	0	13,704	793,388	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-5 Part I | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	6.00	7.00	8.00	
1.00	Administrative and General	1,765	692	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	17,014	6,622	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	50,677	19,723	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	32,161	12,517	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	576	224	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	102,193	39,778	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-5 Part I | Date/Time Prepared: 5/29/2013 8:08 am

Hospice CCN: 151545

Hospice I

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-5 Part I

Hospice CCN: 151545 | Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal (cols. 4A-23)	Hospice I Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	
		15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	16,161			1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	155,726	0	155,726	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	463,839	0	463,839	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	294,364	0	294,364	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	5,269	0	5,269	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	935,359	0	935,359	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-5 Part I Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

	Cost Center Description	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 + 27)	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0	0	2.00
3.00	Inpatient - Respite Care	0	0	3.00
4.00	Physician Services	2,738	158,464	4.00
5.00	Nursing Care	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	6.00
7.00	Physical Therapy	0	0	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech/ Language Pathology	0	0	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Spiritual Counseling	0	0	11.00
12.00	Dietary Counseling	0	0	12.00
13.00	Counseling - Other	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	15.00
16.00	Other	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	8,154	471,993	17.00
18.00	Analgesics	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	19.00
20.00	Other - Specify	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	5,176	299,540	21.00
22.00	Patient Transportation	0	0	22.00
23.00	Imaging Services	0	0	23.00
24.00	Labs and Diagnostics	0	0	24.00
25.00	Medical Supplies	93	5,362	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	26.00
27.00	Radiation Therapy	0	0	27.00
28.00	Chemotherapy	0	0	28.00
29.00	Other	0	0	29.00
30.00	Bereavement Program Costs	0	0	30.00
31.00	Volunteer Program Costs	0	0	31.00
32.00	Fundraising	0	0	32.00
33.00	Other Program Costs	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)		935,359	34.00
35.00	Unit Cost Multiplier (see instructions)	0.017582		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2013 8:08 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A.01	5.01	
1.00	Administrative and General	0	0	373,674	0	13,704	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	132,090	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	393,439	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	249,686	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	4,469	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	373,674		793,388	34.00
35.00	Total cost to be allocated	0	0	13,704		102,193	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.036674		0.128806	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2013 8:08 am

Hospice I

	Cost Center Description	BUSINESS OFFICE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	6.00	7.00	8.00	9.00	
1.00	Administrative and General	13,806	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	132,090	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	393,439	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	249,686	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	4,469	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	793,490	0	0	0	0	34.00
35.00	Total cost to be allocated	39,778	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.050130	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2013 8:08 am

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		Hospice I					
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2013 8:08 am

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REV)	
		16.00	
1.00	Administrative and General	0	1.00
2.00	Inpatient - General Care	0	2.00
3.00	Inpatient - Respite Care	0	3.00
4.00	Physician Services	0	4.00
5.00	Nursing Care	0	5.00
6.00	Nursing Care-Continuous Home Care	0	6.00
7.00	Physical Therapy	0	7.00
8.00	Occupational Therapy	0	8.00
9.00	Speech/ Language Pathology	0	9.00
10.00	Medical Social Services	0	10.00
11.00	Spiritual Counseling	0	11.00
12.00	Dietary Counseling	0	12.00
13.00	Counseling - Other	0	13.00
14.00	Home Health Aide and Homemaker	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	15.00
16.00	Other	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	17.00
18.00	Analgesics	0	18.00
19.00	Sedatives / Hypnotics	0	19.00
20.00	Other - Specify	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	21.00
22.00	Patient Transportation	0	22.00
23.00	Imaging Services	0	23.00
24.00	Labs and Diagnostics	0	24.00
25.00	Medical Supplies	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	26.00
27.00	Radiation Therapy	0	27.00
28.00	Chemotherapy	0	28.00
29.00	Other	0	29.00
30.00	Bereavement Program Costs	0	30.00
31.00	Volunteer Program Costs	0	31.00
32.00	Fundraising	0	32.00
33.00	Other Program Costs	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	34.00
35.00	Total cost to be allocated	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-5 Part III Date/Time Prepared: 5/29/2013 8:08 am

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Hospice I Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.647872	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.202467	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.234749	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.486559	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151310 | Hospice CCN: 151545 | Period: From 01/01/2012 To 12/31/2012 | Worksheet K-6 | Date/Time Prepared: 5/29/2013 8:08 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				935,359	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				7,413	2.00
3.00	Average cost per diem (line 1 divided by line 2)				126.18	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	7,413				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	935,372				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00